

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

15623

State File No.

4425

BIRTH NO. 17758 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY b. CITY (If outside corporate limits, write RURAL and give township) St Louis c. LENGTH OF STAY (In this place) 1mo, 12 days		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY ----- c. CITY (If outside corporate limits, write RURAL and give township) St Louis d. STREET ADDRESS (If rural, give location) 5605 Michigan Av	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Anthony Hospital		d. STREET ADDRESS 5605 Michigan Av	

3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) Renee c. (Last) Black			4. DATE OF DEATH (Month) (Day) (Year) April 29 1953		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Baby	8. DATE OF BIRTH March 17th 1953	9. AGE (In years last birthday) 0	10. CITIZEN OF WHAT COUNTRY? U.S.A
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None		
11. BIRTHPLACE (State or foreign country) St Louis Mo.			12. CITIZEN OF WHAT COUNTRY? U.S.A		

13a. FATHER'S NAME Frank Black	13b. MOTHER'S MAIDEN NAME Edith Gorman	14. NAME OF HUSBAND OR WIFE *****
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Edith Black
ADDRESS 5605 Michigan Av.		

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature Birth ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK - <input type="checkbox"/> NOT WHILE AT WORK - <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 776X

22. I hereby certify that I attended the deceased from 3-17, 1953 to 4-29, 1953, that I last saw the deceased alive on 4-29, 1953, and that death occurred at 3:15 Am., from the causes and on the date stated above.

23a. SIGNATURE Dr. West	23b. ADDRESS 5605 Michigan Av	23c. DATE SIGNED 4/29/53
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE April 30th	24c. NAME OF CEMETERY OR CREMATORY Mt Hope Cem.
24d. LOCATION (City, town, or county) (State) 1200 Lemay Ferry Rd. Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Fey Funeral Home
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE APR 30 1953 J. Earl Smith, M.D.		

WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

S. No. 300
v. 10.48

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision. _____
Student Embalmer No. _____

Student
Student Embalmer

not Embalmed
Signed _____
Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.